DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45th 8/30/14

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and complaint investigations #33124, #34178, #33126, were conducted from July 14, 2014, through July 16, 2014, at Spring City Care and Rehabilitation. No deficiencies were cited in relation to the complaints under 42 CFR PART 483.13, Requirements for Long Term Care.	F 000	Spring City Care and Rehabilitation does not believe and does not admit that any deficiencies existed before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.	F 278	1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident #134 Minimum Data Set (MDS) assessment was modified to include the suspected deep tissue injury on the heel that was not coded on section M of the MDS 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: MDS will audit 100% of residents with pressure ulcers identified by the weekly skin reports for April, May, June to ensure accuracy of section M of the MDS	8/25/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to accurately document the assessment for a pressure ulcer for one resident (#134) of three residents reviewed for pressure ulcers of 42 residents reviewed. The findings included: Resident #134 was admitted to the facility on March 25, 2014, and readmitted on April 1, 2014, with diagnoses including Fractured Rib, Primary Spontaneous Pneumothorax, Hypothyroidism, Benign Prostatic Hypertrophy, and Right Ankle Fixation. Medical record review of the Pressure Ulcer Record dated April 14, 2014, revealed, the resident had a suspected deep tissue injury (Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage or underlying soft tissue from pressure and/or shear) on the left heel. Medical record review of the 14 day Minimum Data Set (MDS) with an assessment reference date of April 17, 2014, revealed, "...Skin Conditions...Does the resident have one or more unhealed pressure ulcer(s) at Stage 1 or higher..." Continued review revealed the documented response was "No." Interview on July 16, 2014, at 3:00 p.m., with Registered Nurse #5 (Wound Care Certified/Treatment Nurse) at the nurse's station confirmed a pressure ulcer was present on the	F 278	3. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: MDS coordinators will verify accuracy of section M of the MDS with weekly skin reports 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: MDS coordinators will conduct 10% audit on those residents who were identified from the weekly skin reports to have Pressure Ulcers Monthly x 3 with results reported to Quality Assurance/Performance Improvement (QAPI) Committee	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 2 resident's left heel during the assessment reference date, and the MDS dated April 17, 2014, was inaccurate.	F 278		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure safety devices were in place for one resident (#87) of three residents reviewed for falls of 42 residents reviewed. The findings included: Resident #87 was admitted to the facility on November 2, 2012, with diagnoses including Dementia with Behaviors, Anxiety, Atrial-Fibrillation, Hypertension, Chronic Obstructive Pulmonary Disease, Benign Prostatic Hypertrophy, Gout, Chronic Kidney Disease Stage 3, Muscle Weakness, and Congestive Heart Failure. Review of the facility investigation dated February 16, 2014, revealed the resident at 8:15 p.m., slid off the side of the bed, and had on regular socks with no shoes. The new intervention was the	F 323	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff were educated 7/16/14 on ensuring safety of Resident # 87 by placing his wheelchair by bedside as stated in care plan. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: Residents with falls have potential to be affected by this practice. Residents that have had recent falls will be reviewed to ensure safety is maintained at highest level and care plan reviewed for compliance and appropriateness 3. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: Staff will be educated by Aug. 22, 2014 on proper supervision of accidents and safety, and to review care plans for interventions to ensure interventions are in place. Director of Nursing (DON)/Designee will audit 25% of care plans of residents with falls, 3 times a week for 4 weeks, then monthly times 3 months to ensure care plans are appropriate and ensure safety is maintained at highest level	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	B. WING	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 3 resident's shoes and wheel chair were to be placed at bedside, accessible for the resident to use. Review of the facility investigations dated March 11, 2014, at 12:45 a.m., April 12, 2014, at 7:30 a.m., May 18, 2014,at 5:00 a.m., June 12, 2014, at 10:30 p.m., June 16, 2014, at 12:05 a.m., and July 9, 2014, at 9:15 p.m., revealed the resident had further falls related to the transferring of self to and from the bed. Observation on July 16, 2014, at 8:56 a.m., in resident #87's room, revealed the resident lying in the bed, and the wheel chair was near the closet, approximately 3 feet from the resident's bed, with no shoes in the wheel chair or on the resident's feet. Observation with the Staff Development Coordinator (SDC) on July 16, 2014, at 9:00 a.m., in resident #87's room revealed the resident lying in the bed and the wheel chair was near the closet approximately 3 feet from the resident's bed, with no shoes in the wheel chair or on the resident's feet. Interview with the SDC at that time confirmed the wheel chair and shoes were not next to the bed, and were not accessible for the resident's safety. Observation on July 16, 2014, at 2:05 p.m., in the resident's room with the SDC revealed the resident's wheel chair was facing the roommate's bed with the brakes applied, and the over the bed table was across the resident's bed between the wheelchair and the bed. Interview at that time with the SDC confirmed the wheelchair and shoes were not within the resident's reach, and the facility failed to ensure safety devices were in	F 323	4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: DON/Designee will audit 25 % of care plans of residents with falls, 3 times a week for 4 weeks, then monthly times 3 months to ensure care plans are appropriate and ensure safety is maintained at highest level. DON/Designee will report results of audit to QA committee	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 4 place.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interview, the facility failed to maintain a sanitary kitchen, as evidenced by: debris, dead insects, and a pool of liquid in the dry storage area, food debris in the deep fryer, debris along the walls and behind equipment of the kitchen, dead insects in the light fixtures of the hood vent, fly swatters on the wall in the kitchen, pans and tilt skillet with built up residue, and ice buildup around the interior doorway of the walk in freezer. The findings included: Observation with the Kitchen Charge Team Member #1 and Cook #2 on July 14, 2014, at 9:55 a.m., in the kitchen revealed the following: 1. Ice buildup around the door of the interior of the large walk in freezer including across the threshold. 2. Debris along walls, corners and behind	F 371	What corrective action will be accomplished for those residents found to have been affected by the deficient practice: All dietary staff was in-serviced on policy & procedure for sanitation /infection control for dietary to ensure a sanitary kitchen. Specific in-service was provided for ice buildup on walk in freezer, debris along walls, corners, behind equipment, dead insects, build up residue on pans & tilt skillet, proper maintenance of deep fryer and removal of fly swatters. Staff in-serviced on maintaining sanitary conditions in dry storage area and proper storage of items. The continuous drip from ceiling was not evident when Life Safety inspector and Plant Operations Director inspected dry storage area previous to State Surveyor inspection. Plant Operations Director was notified and leak was immediately repaired 7/14/2014 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have potential to be affected by this practice	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 5 equipment of the kitchen. 3. Dead insects in the six light fixtures of the hood vent. 4. Built up residue on pans and tilt skillet. 5. Deep fryer with food residue floating on top of the grease. 6. Two Fly swatters noted on wall in kitchen. Observation and interview with Kitchen Charge Team Member # 1 in the kitchen on July 16, 2014, at 10:35 a.m., revealed the following: 1. The dry food storage area revealed debris on the floor including; food items, dead insects, in addition to insects on glue traps, and miscellaneous debris. 2. A large pool of a liquid substance at the back of the dry food storage room, which was coming from a continuous drip from the ceiling. 3. A large box on a shelf containing plastic forks in a plastic bag, near the entrance of dry food storage area, which had a significant dried water/moisture stain on it. Review of the facility policy for Food Storage, (no date on policy), revealed "...Food is stored a minimum of 6 inches above the floor on clean racks, dollies or other clean surfaces, and is protected from splash, overhead pipes, or other contamination..." Review of the facility policy for sanitation/infection control for dietary, (no date on policy), revealed, "...A clean department is essential for good sanitation. The department includes the equipment, materials, that are used, floors, walls, cleaning is important...Walls, ceilings, and floors are cleaned routinely...All kitchen areas and equipment shall be maintained in a sanitary	F 371	3. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: All areas of deficient practice indicated have been corrected and assigned to specific positions for cleaning and/or maintaining to ensure sanitary conditions. Replacement sheet pans have been ordered 7/21/2014. 4. How the corrective action will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: Certified Dietary Manager (CDM) and Administrator to do weekly inspections times 4 weeks then monthly in addition to the Registered Dietitian's monthly inspections. Weekly audit by CDM for deficient areas times 4 weeks then monthly times 3 months. Results to be reported to QAPI Committee.	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 6 manner and be free of buildup of food, grease or other soil. The facility will provide sanitary foodservice that meets state and federal regulations..." Interview with the dietary manager, on July 14, 2014, at 10:45 a.m., in the kitchen confirmed the ice buildup around the door of the interior of the large walk in freezer including across the threshold, debris along walls, corners and behind equipment of the kitchen, dead insects in the six light fixtures of the hood vent, excessive residue on pans and tilt skillet, grease fryer with food residue floating on top and two fly swatters noted on wall in kitchen. Continued interview confirmed debris on the floor of the dry storage area, a pool of a liquid substance at the back of the storage area, and a moisture stain on a box of plastic forks on a shelf of the dry storage area.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441	1.What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Staff passing trays on the hall were educated on infection control and proper way of handling meal trays and food on trays by the Director of Nursing (DON) on July 21, 2014. 2. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken: All residents have potential to be affected by this practice. Staff will be observed passing meal trays by Director of Nursing/Assistant Director of Nursing/Staff Development Coordinator/Restorative	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 7 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review and interview, the facility failed to distribute food in a sanitary manner for four of twenty-seven food trays observed delivered to residents. The findings included: Observation on July 14, 2014, of lunch trays being delivered to four resident's in their rooms revealed: Certified Nurse Assistant (CNA) #4 at 12:05 p.m., the CNA obtained from the food cart the lunch tray for room 410 b, and delivered it to the room; with the bare hands moved the over the bed table, removed the top of the bun and laid it on the plate; opened the mayonnaise packet; squeezed mayonnaise on to the bun; replaced	F 441	Manager or designated person for compliance in infection control with emphasis on food handling. 3. What measure will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur: Staff will be educated on infection control policies with emphasis on passing resident meal trays and handling food items by the DON/Designee by 8/22/2014. Random observations of passing trays during meals will be conducted by DON/Designee for compliance in infection control policies with emphasis on handling food items 3 meals/week for 4 weeks then monthly for 3 months. 4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur; i.e., what quality assurance program will be put into place: Random observations of passing trays during meals will be conducted by DON/Designee for compliance in infection control policies with emphasis on handling food items 3 meals/week for 4 weeks then monthly for 3 months. DON/Designee will report findings of observations to QAPI Committee monthly	8/25/2014

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 8 the top of the bun; and cut the hamburger in half. Continued observation revealed CNA #4 washed the hands; went out to the hallway; and at 12:10 p.m., with the bare hands obtained room 401 b's lunch tray, took it to the resident's room; moved the over the bed table; assisted the resident to sit on the side of the bed; moved the over the bed table in front of the resident; removed the top of the bun; opened the mayonnaise packet; spread mayonnaise on to the bun; placed the lettuce and tomato on the bun; replaced the bun top onto the hamburger, and cut the hamburger in half. Continued observation revealed CNA #4 went out to the hallway; used sanitizer on the hands, and at 12:16 p.m., with the bare hands obtained room 402 a's lunch tray; took it to the resident's room; moved the over the bed table; used the control to put the head of the bed up, removed the top of the bun; opened the mayonnaise packet and spread it on to the bun top, replaced the top of the bun onto the ground hamburger; cut the ground hamburger into 1/4 pieces; lifted each top of the bun and used a spoon to scoop tomato and onion onto the ground burger; and handed a 1/4 of the ground hamburger to the resident. Continued observation revealed CNA #4 went into the bathroom and washed the hands; went into the hallway and at 12:19 p.m., went into room 405 applied gloves to the bare hands, and removed a used urinal from the over bed table, sanitized the over the bed table, removed the gloves, went into the bathroom and washed the hands; went into the hall way and with the bare hands obtained 405 a's lunch tray and took it into the room; moved the over the bed table; removed the top of the bun, opened the mayonnaise packet, spread it onto the bun, placed the lettuce and tomato onto the bun; and cut the hamburger into 1/2.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445209	A. BUILDING _____ B. WING _____	07/16/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING CITY CARE AND REHABILITATION CENTER	331 HINCH STREET SPRING CITY, TN 37381

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 9 Interview on July 15, 2014, at 12:25 p.m., with CNA #4 in the 400 hallway confirmed the CNA handled the resident's hamburgers with the bare hands. Review of the facility's Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices dated December 2008, revealed "...8. Contact between food and bare (ungloved) hands is prohibited..." Interview with the Director of Nursing on July 16, 2014, at 2:32 p.m., in the conference room confirmed the staff are not to handle resident's food without the hands being gloved.	F 441		